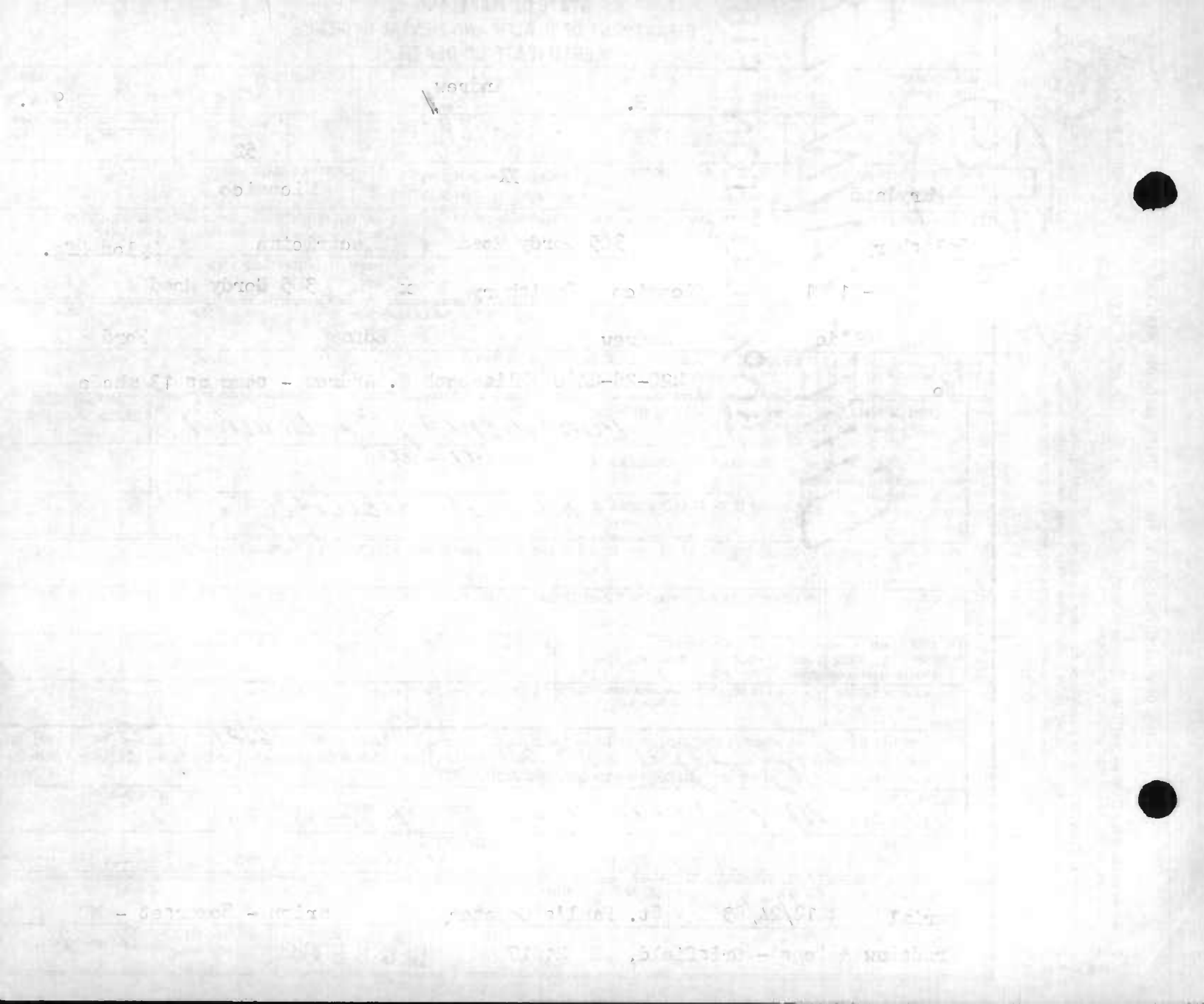


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)		First KENNETH		Middle F.		Last Andrew ANDREW		2a. DATE OF DEATH Month 12 Day 22 Year 83			2b. HOUR 9 A.M.		
3. SEX MALE		4. RACE CAUCASION		5. DATE OF BIRTH 8/19/31			6. AGE (In years last birthday) 52 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico							
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 305 Gordy Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Electrician			12b. KIND OF BUSINESS OR INDUSTRY Nylon Mfg.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD-21801			13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 305 Gordy Road 21801				
14. FATHER'S NAME First Ollie			Middle Andrew		Last Edna		15. MOTHER'S MAIDEN NAME First Edna			Middle Ford		Last Ford	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220-28-0460		17. INFORMANT Address Elizabeth W. Andrew - same as 13 abcde									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Epididymid 1820 DUE TO, OR AS A CONSEQUENCE OF metastatic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General debility DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		UNDERLYING <input type="checkbox"/> 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 12/21 , 19 83 , to 12/21 , 19 83 , that (I) (we) last saw the deceased alive on 12/21 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Heleen M. Baldado, M.D.					DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) HELEN M. BALDADO, M.D.					22e. ADDRESS 547-F Riverside Dr, Salisbury MD 21801								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/24/83		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery			23d. LOCATION (City or Town) (County) (State) Marion - Somerset - MD						
24. FUNERAL DIRECTOR Bradshaw & Sons - Crisfield, MD 21817					ADDRESS		25a. REC'D BY REGISTRAR DEC 28 1983		25b. REGISTRAR'S SIGNATURE John J. Smith				



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA APOLENAK			2a. DATE OF DEATH MONTH DAY YEAR 12-3-83		2b. HOUR 6:30 a.m.
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 1-25-1901		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE STATE OR FOREIGN CZECH.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.	
10. CITY OR TOWN OF DEATH SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) LEGAL STENOGRAPHER	12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY WICOMICO	13c. CITY OR TOWN SALISBURY	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Rt 250 + Civic Ave
14. FATHER'S NAME FIRST MIDDLE LAST John APOLENAK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Z DRAZIL		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 167-03-4298		17. INFORMANT ADDRESS Charles J. KUCERA 60 LINDA LANE Millersville, MD			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARRESTAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHIMMEDIATE

4140
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) CONGESTIVE HEART FAILUREMONTHS

DUE TO, OR AS A CONSEQUENCE OF

(c) ARTERIOSCLEROTIC HEART DISEASEYEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

CEREBROVASCULAR ACCIDENT - LEFT HEMIPARESIS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <u>NOV 24</u> , 19 <u>83</u> , to <u>DEC 3</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>DEC 1</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>John M. Buchwess</u>	DEGREE	ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12-3-83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN M. BUCHWESS		22e. ADDRESS SALISBURY NURSING HOME SALISBURY, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIAL) CREMATION	23b. DATE 12-3-1983	23c. NAME OF CEMETERY OR CREMATORY DeLmarva Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Lewes, Sussex Del.
24. FUNERAL DIRECTOR NAME Baker & Bounds		25a. DATE REC'D. BY REGISTRAR DEC 7 1983	
ADDRESS SALISBURY, MD		25b. REGISTRAR'S SIGNATURE John J. Conner	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON

THE EXAM



11-1-88

Examination 11-1-88
Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

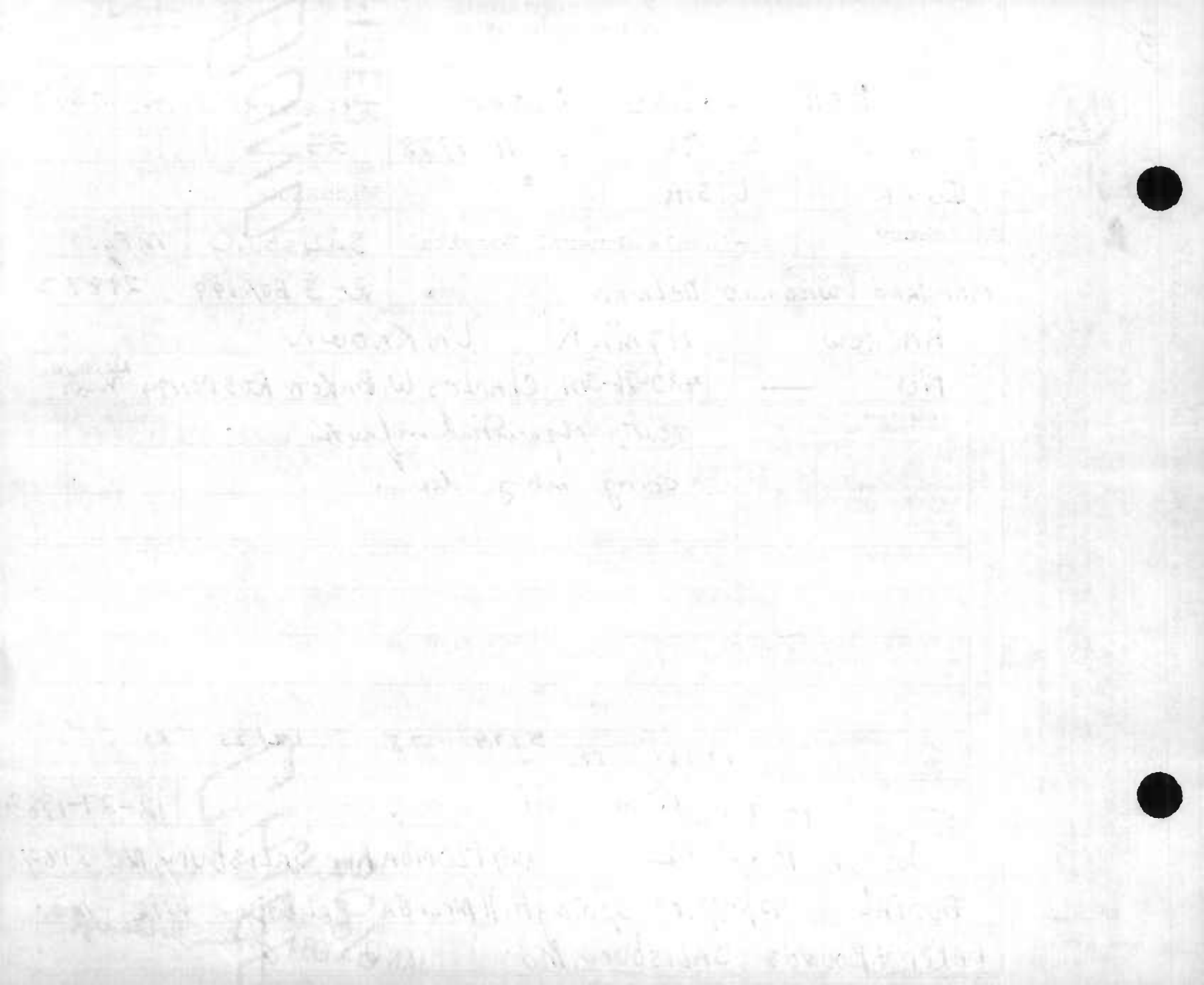
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Betty Louise Baker				2a. DATE OF DEATH MONTH DAY YEAR December 25 1983	
3. SEX Female		4. RACE white		2b. HOUR 0307h	
5. DATE OF BIRTH MONTH DAY YEAR 6 11 1928		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IOWA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				10. CITY OR TOWN OF DEATH Salisbury	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALISBURY	
12b. KIND OF BUSINESS OR INDUSTRY Mfg.				13a. STATE MARYLAND 13b. COUNTY Wicomico 13c. CITY OR TOWN Delmar	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Hymick				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 480-26-5151	
17. INFORMANT ADDRESS Charles W. Baker Rt 3 Box 199 Delmar Md.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) 4100	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/24 19 78 , to 12/25 19 83 , that (I) (we) lost saw the deceased alive on 12/25 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Joseph Z. Sater		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-27-1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Bachos		22e. ADDRESS 229 Florida Ave Salisbury, Md 21804			
23a. BURIAL, CREMATION, REMOVAL (SPRINT) BURIAL		23b. DATE 12/29/1983		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Memo GA	
23d. LOCATION CITY OR TOWN COUNTY STATE SALISBURY Wic. MD.		24. FUNERAL DIRECTOR Baker & Bouds ADDRESS SALISBURY, Md.			
25a. DATE REC'D. BY REGISTRAR JAN 03 1984		25b. REGISTRAR'S SIGNATURE John J. Sater			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR						
1. DECEASED NAME (TYPE OR PRINT)			FIRST Ann	MIDDLE Sallie	LAST Banks	2a. DATE OF DEATH MONTH DAY YEAR December 10, 1983
3. SEX female			4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 03 02 1907	6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS	2b. HOUR 00 15 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired quality control
13a. STATE Maryland			13b. COUNTY Wicomico	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Woodlin F. Brittingham			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Ellen Hayman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-32-6405		17. INFORMANT ADDRESS Mrs. Pat Wilcox (Daughter) 114 Somerset Avenue, Cambridge, Md. 21613	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pneumonia</u> <u>5770</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>chron cholelith and cholelith</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION <u>30 Nov 83</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Acute pneumonia</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>28 Nov</u> 19 <u>83</u> to <u>10 Dec</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>10 Dec</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Andrew J. Forgash</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10 Dec 83</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew J. Forgash, M.D.		22e. ADDRESS Medical Center, Salisbury, Md. 21801				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/13/83		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Maryland
24. FUNERAL DIRECTOR Holloway Funeral Home, P.A. ADDRESS Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR DEC 16 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>

Elbowy Funeral Home, P.A., Salisbury, Md.

12/13/83

Persons Company

Salisbury-Wisconsin Maryland

Andrew J. Forgan, M.D.

Medical Center, Salisbury, Md. 21801

to

214-32-8405

111 Somerset Avenue, Cambridge, Md. 21613
Mrs. Pat Wilcox (Daughter)

Woodlin F.

Brittingham

Dore

Ellen

Rayson

836 Schumaker Drive, 21801

Maryland

Wisconsin

Salisbury

U.S.A.

x

21 12 1987

78

Salisbury

December 19 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAY C. Beauchamp				2b. HOUR 6:35 a.m.			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb. 16, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS	
7a. PLACE OF BIRTH (CITY OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland 13b. COUNTY Somerset 13c. CITY OR TOWN Pocomoke				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS route #1, Box 158	
14. FATHER'S NAME FIRST MIDDLE LAST Jessie Lee Cowger				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vernon B. Kerr			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 216-40-3822		17. INFORMANT ADDRESS route #1, Box 157 Pocomoke City, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Duodenal ulcer disease							1 MONTH
DUE TO, OR AS A CONSEQUENCE OF (b) malnutrition							
DUE TO, OR AS A CONSEQUENCE OF (c) Organic brain Syndrome							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Gastrintestinal Bleed							
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/89 to 12/83, that (I) (we) last saw the deceased alive on 12/1, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. O. Meadows M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/21/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. O. Meadows				22e. ADDRESS 540 Riverside Dr #4 Salisbury Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/4/83		23c. NAME OF CEMETERY OR CREMATORY First Baptist Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Pocomoke Worcester Md.	
24. FUNERAL DIRECTOR Scott S. Nelson				25a. DATE REC'D. BY REGISTRAR DEC 6 1983		25b. REGISTRAR'S SIGNATURE John J. Gairish	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 8 3 3 4 4 1 7			
1. FOR STATE REGISTRAR						2a. DATE OF DEATH			
1. DECEASED NAME FIRST MIDDLE LAST Elizabeth (BETTY) J, BODDINGTON						MONTH DAY YEAR 12 20 83		2b. HOUR 6:15 P.M.	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 9 18 1896		6. AGE (IN YEARS LAST BIRTHDAY) 87		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.			
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Social Worker		12b. KIND OF BUSINESS OR INDUSTRY Red Cross	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY Balto.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14. STREET ADDRESS 3203 N. Charles St.			
14. FATHER'S NAME FIRST MIDDLE LAST Micah J. Jenkins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Natalie Whaley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. 103-26-6666		17. INFORMANT ADDRESS Tom Scarburgh			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterial Thrombosis 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) generalized arterio sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day. yes.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 11/8 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) 12/20 83				
21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11/8 83 12/20 83		22a. I certify that (I) (this hospital) attended the deceased from 12/20 83 to 12/20 83 , that (I) (we) lost 11/8 83 saw the deceased alive on 12/20 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (a) (b) (c) (d) (did not) view the body after death.				
22b. SIGNATURE DR. EARL BEARDSLEY			DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/20/83	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12/22/83		23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Sussex De.		
24. FUNERAL DIRECTOR NAME Larrimore Pippin			ADDRESS Wyoming, Ne.		25a. DATE REC'D BY REGISTRAR DEC 27 1983		25b. REGISTRAR'S SIGNATURE John J. Smith		

FILED



12522182 Delaware Crematory, Sussex Co.

Partnership with Hyman, et al.

103-10-0000 Tom Scarborough

John J. Jenkins, Natalie Whaley

1207 N. Charles St.

West. Social Worker and Care

South Carolina, U.S.A.

Female

Elizabeth ()

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) James BOOHER			2a. DATE OF DEATH MONTH DAY YEAR December 17, 1983			2b. HOUR 11:15 a.m.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 8 12		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auto		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY WIC		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William Major Booher			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Isabel Fleenor			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Unkn.			
16b. SOCIAL SECURITY NO. 381-07-6513			17. INFORMANT ADDRESS Mr. K. King Burnett 115 Brown St. Slisbury, Md. 21801						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>carcinoma of the throat</u> <u>1490</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Nancy W. Tustin, M.D.</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nancy W. Tustin, M.D.					22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 12/17/83		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board					ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR DEC 22 1983		
					25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or any of items 21a through 21g are marked, the medical examiner must be notified by the funeral director.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Brady C. Bounds Jr					2a. DATE OF DEATH MONTH DAY YEAR Dec 22, 1983				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR May 8, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS		7b. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kaywood Drive				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Heckelshunk Depts man		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Kaywood Dr Rt 7	
14. FATHER'S NAME FIRST MIDDLE LAST Brady C. Bounds		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NANNIE Adkins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 219-07-6008		17. INFORMANT ADDRESS MARGARET P. Bounds, (Staten 13E)					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pancreatic Cancer DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 5/24 19 83 , to 12/22 19 83 , that (I) (we) last saw the deceased alive on 11/24 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE David E. Cowall, MD					DEGREE		22c. DATE SIGNED 12/24/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David E. Cowall, M.D.					22e. ADDRESS 1300 S. Division St Salisbury, MD 21801				
23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL		23b. DATE 12-24-1983		23c. NAME OF CEMETERY OR CREMATORY PARSONS Cem.		23d. LOCATION (CITY OR TOWN) COUNTY STATE Salisbury Wicomico			
24. FUNERAL DIRECTOR NAME Baker & Bounds, Salisbury, Md.					25. DATE OF REGISTRATION DEC 27 1983				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

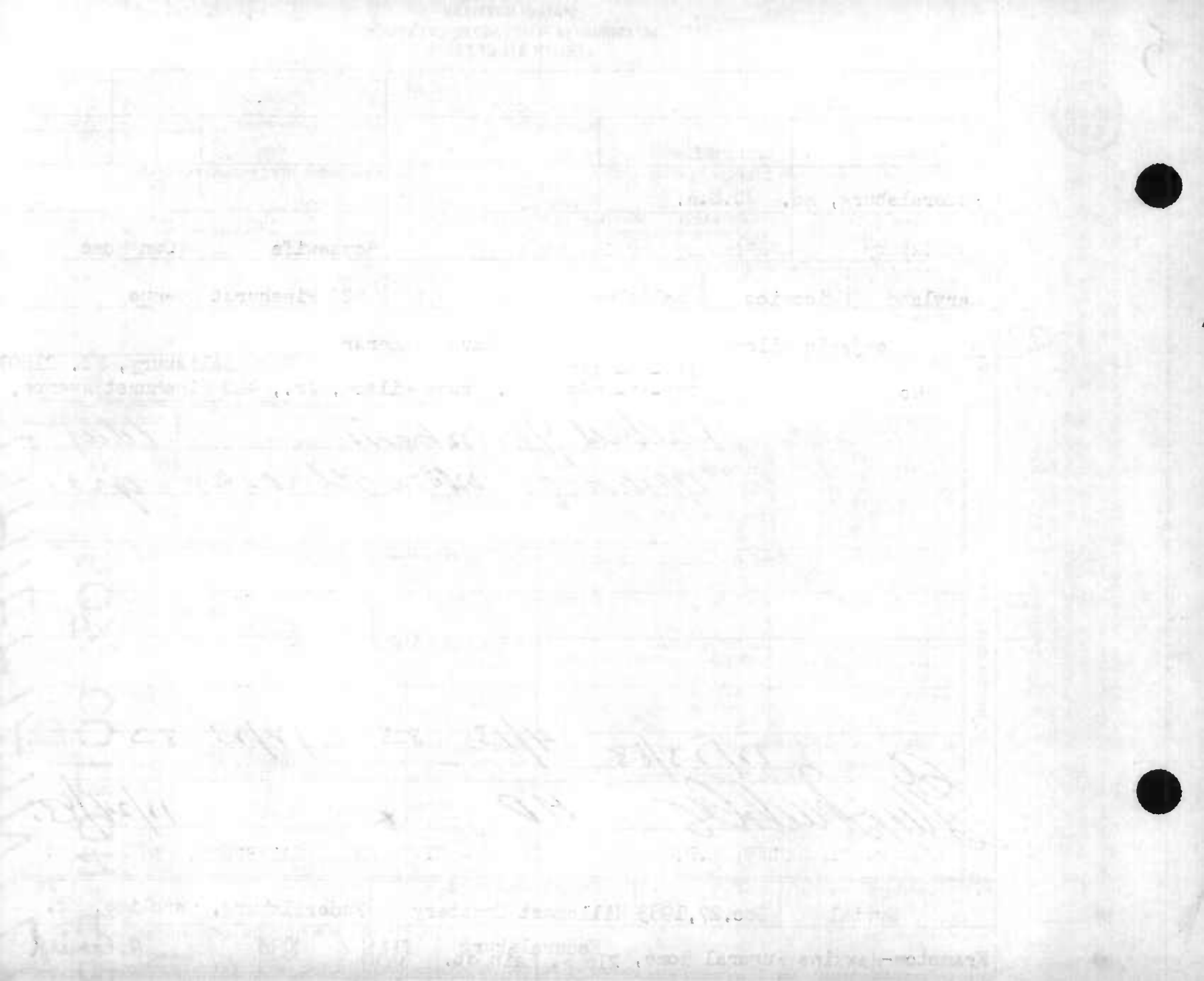
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT) ESTHER M. Brooks		12		23	83	8:30p.m.	
1. SEX Female	4. RACE Caucasian	3. DATE OF BIRTH MONTH DAY YEAR 10 25 1882		6. AGE (IN YEARS LAST BIRTHDAY) 101 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Federalburg, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Salisbury Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Maryland		13b. COUNTY Wicomico	13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Wilson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Dudderar		13e. STREET ADDRESS 420 Pinehurst Avenue 21801			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-05-9137 723-21-6065		17. INFORMANT ADDRESS Salisbury, Md. 21801 W. Bruce Wilson, Jr., 420 Pinehurst Avenue,			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 4390 DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>generalized arterio sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i> yrs.</i>							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>4/13</i> 19 <i>83</i> to <i>11/23</i> 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>11/23/83</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.							
22b. SIGNATURE <i>Earl M. Beardsley</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/24/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EARL M. BEARDSLEY, M.D.		22e. ADDRESS US 50 - CIVIC AVE., SALISBURY, MD. 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 27, 1983		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Federalburg, Caroline, Md.	
24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home,		ADDRESS 216 N. Main St.		25a. DATE REC'D. BY REGISTRAR JAN 4 1984		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) KENNETH GEORGE BROWN			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 21, 1983			2b. HOUR 0908 M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB 21, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Exchange Sys.	
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Keats Circle 21901	
14. FATHER'S NAME FIRST MIDDLE LAST W. Hiram Brown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Schnitzell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 011-20-2391		17. INFORMANT ADDRESS MAY R. BROWN, (Same as 13c)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROSTATE CANCER 1850 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from NOW 19 83 , to 12/21 19 83 , that (I) (we) lost saw the deceased alive on 12/10 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
23a. SIGNATURE David E. Cowell						DEGREE MD		23b. DATE SIGNED 12/21/83	
23c. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID E. COWELL, MD						23d. ADDRESS 1306 S. Division St. Salisbury, Md 21801			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12-23-1983		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Md.		
24. FUNERAL DIRECTOR NAME Baker & Bouds						ADDRESS Salisbury Md		25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE DEC 27 1983 John J. Lander	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP _____

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE E LAST BUNTING			2a. DATE OF DEATH MONTH 12 DAY 07 YEAR 1983			2b. HOUR 2:30 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH April DAY 23 YEAR 1982		6. AGE (IN YEARS LAST BIRTHDAY) 101 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.	
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST William MIDDLE Henry LAST Mason		15. MOTHER'S MAIDEN NAME FIRST Melissa MIDDLE Somers LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 21446-4110	
17. INFORMANT Louise Shay		18. ADDRESS Route 2, Box 258 Pocomoke City, Md 21851		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. DATE OF OPERATION		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 3</u> , 19 <u>82</u> , to <u>DEC. 7</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>DEC 5</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>John M. Buchness</u> M.D.		22c. DATE SIGNED 12/7/83		22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN M. BUCHNESS, M.D.	
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 3</u> , 19 <u>82</u> , to <u>DEC. 7</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>DEC 5</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>John M. Buchness</u> M.D.		22c. DATE SIGNED 12/7/83		22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN M. BUCHNESS, M.D.	
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 3</u> , 19 <u>82</u> , to <u>DEC. 7</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>DEC 5</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>John M. Buchness</u> M.D.		22c. DATE SIGNED 12/7/83		22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN M. BUCHNESS, M.D.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/10/83		23c. NAME OF CEMETERY OR CREMATORY First Baptist Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Pocomoke Worcester Md	
24. FUNERAL DIRECTOR Scott S. Melson		24a. ADDRESS Pocomoke City, Md		25a. DATE REC'D. BY REGISTRAR DEC 13 1983		25b. REGISTRAR'S SIGNATURE James E. Carver	

MEDICAL CERTIFICATION

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4292

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

CONGESTIVE HEART FAILURE

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 WEEK

(b) ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE

YEARS

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK ☐ AT WORK ☐21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from SEPT 3, 19 82, to DEC. 7, 19 83, that (I) (we) last saw the deceased alive on DEC 5, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS
SALISBURY NURSING HOME
SALISBURY, M.D.

23a. BURIAL, CREMATION, REMOVAL

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

24. FUNERAL DIRECTOR

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

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BP

Female
Virginia

White
U.S.A.

April 22 1962

101

Housewife
X Clark Avenue

Marion Winston
William Henry

Miss

214-4110
214-4110



W. C. CO. CO.

Paul
Satan - Satan